AIKEN COUNTY Finance Department Central Collections Signature/Information Request	AC-FNC101 (9/02)
828 Richland Ave W. Aiken, SC 29801 803/642-2067 Fax: 803/642-2071	

Aiken County EMS is required by Federal law to submit all Medicare claims for services provided. This office will also file Medicaid and health insurance claims if all information is available and there is a signature on file. Please sign where indicated and provide the insurance information, if requested. If this form is not returned within TEN (10) days then a delay in claims filing and receipt of payment can be expected.

INSURANCE INFORMATION

_____ Name and mailing address if Insurance Company.

_____ Name of the INSURED, their Social Security Number, Policy and Group Number and relationship to the patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND WAIVER:

I hereby authorize Aiken County Emergency Services to release medical information about this service to the Hospital attending Physician, Insurance carrier and Blue Cross/Blue Shield. If this is Medicare coverage, to the Health Care Financing Administration or its Intermediaries/Carriers. If there is Medicaid, to the appropriate Medicaid Agency in the patients home state. Also, Claims Representatives or Adjusters (Auto and Medical) and Attorneys representing the patient. Furthermore, I authorize the release of medical information pertaining to this EMS call to Aiken County Emergency Services for the purpose of quality improvement. All information obtained is for the purpose of treatment, payment or EMS operations.

_____ _____

Signed (Insured/Authorized Person) Witness

( ) Due to medical conditions, patient is unable to sign. ( ) Patient's Mark and Witness ( ) Other

ASSIGNMENT OF INSURANCE AND PAYMENT AGREEMENT:

I hereby authorize payment of all Insurance Benefits, including Major Medical, Title XVIII Medicare, Title XIX Medicaid, Automobile Insurance, Workman's Compensation (State and Federal), and Blue Cross/Blue Shield. I understand that I am responsible to Aiken County Emergency Service for charges not covered by this assignment (co-insurance, deductible and non-covered services) and that any credit balance will be transferred to other Ambulance Account for which I am responsible. I permit a copy of this authorization to be used in place of the original document.

_____ _____

Signed (Insured/Authorized Person) Witness

( ) Due to medical conditions, patient is unable to sign. ( ) Patient's Mark and Witness ( ) Other

If you have questions, please call this office at (803) 642-2067 or 642-2071.

Patients Name _____

Call Number/Date _____

Account Number _____